U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 31May2002

CASE NO.: 2001-BLA-754

In the Matter of:

JOHNNIE RUTH HERRON, Survivor of
Raymon Herron,
Claimant

v.

WESTMORELAND COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party in Interest

APPEARANCES:

Frederick K. Muth, Esquire
For the Claimant

Mary Rich Maloy, Esquire
For the Employer

BEFORE: ROBERT J. LESNICK
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972 and the Black Lung Benefits Reform Act of 1977, 30 U.S.C. § 901 et seq. [hereinafter referred the Act]. This case was referred to the Office of Administrative Law Judges by the District Director, Office of Workers' Compensation Programs on April 27, 2001.

In a case involving a deceased coal miner, benefits are awarded to survivors of a miner whose death was caused by pneumoconiosis. Pneumoconiosis is defined in the Act as a chronic dust disease of the lungs arising from coal mine employment and the disease is commonly known as black lung.

Following proper notice to all parties, a formal hearing was held in regard to this claim on November 14, 2001 at Beckley, West Virginia. The Director's exhibits were offered in evidence at the hearing pursuant to 20 C.F.R. § 725.456, and the parties were afforded the opportunity to present additional evidence. Counsel also were allowed to submit closing arguments or briefs.

The findings of fact and conclusions of law set forth in this decision are based upon my analyses of the entire record and my observation of the demeanor of the witness who testified at the hearing. Each exhibit and argument of the parties, although perhaps not specifically mentioned, has been carefully reviewed and thoughtfully considered. Where the contents of certain medical evidence in the record appear inconsistent with the conclusions reached in this decision, it should be considered that the appraisal of the relative merits of each item of medical evidence has been conducted in conformance with the quality standards of the regulations.

Section numbers hereinafter cited exclusively pertain to Title 20, Code of Federal Regulations. References to DX, CX, EX and ALJX pertain to the exhibits of the Director, Claimant, Employer and Court respectively. At the time of the hearing, Director's Exhibits No. 1 through 39, Claimant's Exhibits Nos. 1 and 2[1], Employer's Exhibits Nos. 1 through 5, and Administrative Law Judge's Exhibits Nos.1 and 2 were admitted to the record. By letter dated January 14, 2002, Employer submitted four additional exhibits marked as Employer's Exhibits Nos. 6 through 9. No objection to these exhibits was received. All parties were afforded the opportunity to submit closing arguments or briefs. All of this evidence has been made a part of the record in this claim.

ISSUES

The following controverted issues remain for decision:

1. Whether the miner had pneumoconiosis as defined by the Act and regulations;

2. Whether his pneumoconiosis arose out of coal mine employment;

3. Whether the miner was totally disabled;

4. Whether the miner's death was due to pneumoconiosis;

5. Whether the named employer is the operator responsible for the payment of benefits;

6. Whether the named employer has secured the payment of benefits; and,

7. Whether the miner's most recent period of cumulative employment of not less than one year was with the named responsible operator.

(DX 39; Tr. 8).

[1] Under cover letter dated December 7, 2001, Claimant submitted the deposition testimony of Dr. Rasmussen. By that same letter, Claimant advised the undersigned that Dr. Boustani had declined to offer deposition testimony. Therefore, Claimant's evidence consists of only one exhibit although two were admitted at the time of the hearing.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Johnnie Ruth Herron, ("Claimant") married Raymon Herron ("the miner") on April 20, 1957. Mr. Herron died on August 14, 1999. The cause of his death was listed in the certificate of death as pneumoconiosis. Mrs. Herron has not remarried. (DX 1, 6, 7).

Mrs. Herron filed the survivor's claim involved in this proceeding on August 27, 1999. The application was considered by the Director, Office of Workers' Compensation Programs and denied on March 9, 2000 and again on March 12, 2001. An appeal to the Office of Administrative Law Judges was filed on March 16, 2001. (DX 1, 11, 30, 33).

At the time of the formal hearing, Claimant testified that she married the miner on April 20, 1957 and she has not remarried since the time of the miner's death on August 14, 1999. (TR 10). At the time of his death, the miner was receiving benefits for black lung disability. (TR 10). The miner was also receiving benefits from the state workers' compensation fund, although Claimant was not certain of the details of this payment. (TR 11). Claimant stated that the miner was last employed by Westmoreland Coal Company as an outside utility man until 1985. (TR 11).

Claimant went on to describe the miner's breathing difficulties as including not being able to walk, experiencing difficulty in catching his breath and the inability to perform manual labor. (TR 12). Claimant testified that the miner's problems became worse in the two year prior to his death. (TR 12). The miner was treated for his lung disease at Southern West Virginia Clinic by Dr. Bavari and Dr. Boustani. (TR 12). Claimant stated that the miner's treatment included oxygen treatments, the use of a "breathing machine" and a nebulizer. (TR 13).

On cross-examination, Claimant testified that the miner smoked for "many years." (TR 13). However, Claimant went on to state that the miner quit smoking 15 to 20 years before he ceased being employed in the coal mining industry in 1985. (TR 13). Claimant stated that the miner worked regular shifts on a regular basis up until 1985. (TR 14). Claimant clarified that the miner was never told that he was suffering from lung cancer. (TR 14).

Pneumoconiosis and Related Issues

I. Medical Evidence

The medical evidence of record is as follows:

A. X-rays

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
7/22/65	DX 8	C.W. Nelson	2/2
9/29/69	DX 8	T. L. Martin	No significant abnormalities
7/26/72	DX 8	C. W. Nelson	Category 2, p

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
2/26/74	DX 8	T. L. Martin	Pneumoconiosis I, s
5/17/83	DX 8	T. L. Martin	Pneumoconiosis I, p
4/24/84	DX 8	T.L. Martin	Pneumoconiosis I, p
5/21/84	DX 8	T. L. Martin	Pneumoconiosis I, p
4/9/85	DX 8	L. Speiden	Fine nodularity peripherally compatible with pneumoconiosis
6/3/86	DX 8	L. Speiden	Pneumoconiosis I, p
4/6/87	DX 8	L. Speiden	Pneumoconiosis 1/1, p/t
4/14/88	DX 8	C. R. Daniel	Pneumoconiosis 1/2
4/21/89	DX 8	L. Speiden	Small peripheral parenchymal densities consistent with simple pneumoconiosis
3/21/90	DX 8	L. Speiden	Small peripheral parenchymal densities consistent with simple pneumoconiosis
8/15/91	DX 8	L. Speiden	Small peripheral parenchymal densities consistent with simple pneumoconiosis
2/3/94	DX 8	M. Patel	Simple pneumoconiosis
2/3/94 (9/5/00)	DX 25	P. Wheeler/Board certified radiologist and B-reader	Completely negative
2/3/94 (9/5/00)	DX 25	W. Scott, Jr./Board certified radiologist and B-reader	Completely negative
2/3/94 (12/1/00)	DX 27	J.F. Wiot/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
2/3/94 (12/22/00)	DX 28	H.B. Spitz/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
2/3/94 (2/26/01)	DX 32	R.T. Shipley/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
2/3/94 (3/8/01)	DX 34	C.A. Meyer/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
2/3/94 (10/3/01)	EX 3	J.R. Castle/B-reader	Completely negative
6/24/98	DX 8	M. Patel	Simple pneumoconiosis
6/24/98 (9/5/00)	DX 25	P. Wheeler/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
6/24/98 (9/5/00)	DX 25	W. Scott, Jr./Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
6/24/98 (12/1/00)	DX 27	J.F. Wiot/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
6/24/98 (12/22/00)	DX 28	H.B. Spitz/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
6/24/98 (2/26/01)	DX 32	R.T. Shipley/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
6/24/98 (3/8/01)	DX 34	C.A. Meyer/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
6/24/98 (10/3/01)	EX 3	J.R. Castle/B-reader	No parenchymal abnormalities consistent with pneumoconiosis
9/28/98	DX 8	M. Patel	Simple pneumoconio-sis

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
9/28/98 (9/5/00)	DX 25	P. Wheeler/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
9/28/98 (9/5/00)	DX 25	W. Scott, Jr./Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
9/28/98 (12/1/00)	DX 27	J.F. Wiot/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
9/28/98 (12/22/00)	DX 28	H.B. Spitz/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
9/28/98 (2/26/01)	DX 32	R.T. Shipley/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
9/28/98 (3/8/01)	DX 34	C.A. Meyer/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
9/28/98 (10/3/01)	EX 3	J.R. Castle/B-reader	No parenchymal abnormalities consistent with pneumoconiosis
1/11/99	DX 8	M. Patel	Simple pneumoconiosis
1/11/99 (9/5/00)	DX 25	P. Wheeler/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
1/11/99 (9/5/00)	DX 25	W. Scott, Jr./Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
1/11/99 (12/1/00)	DX 27	J.F. Wiot/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
1/11/99 (12/22/00)	DX 28	H.B. Spitz/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
1/11/99 (2/26/01)	DX 32	R.T. Shipley/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
1/11/99 (3/8/01)	DX 34	C.A. Meyer/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
1/11/99 (10/3/01)	EX 3	J.R. Castle/B-reader	No parenchymal abnormalities consistent with pneumoconiosis
5/10/99	DX 8	M. Patel	Simple pneumoconio-sis
5/10/99 (9/5/00)	DX 25	P. Wheeler/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
5/10/99 (9/5/00)	DX 25	W. Scott, Jr./Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
5/10/99 (12/1/00)	DX 27	J.F. Wiot/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
5/10/99 (12/22/00)	DX 28	H.B. Spitz/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
5/10/99 (2/26/01)	DX 32	R.T. Shipley/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
5/10/99 (3/8/01)	DX 34	C.A. Meyer/Board certified radiologist and B-reader	No parenchymal abnormalities consistent with pneumoconiosis
5/10/99 (10/3/01)	EX 3	J.R. Castle/B-reader	No parenchymal abnormalities consistent with pneumoconiosis

B. CT Scans

3/27/98	DX 28	C.R. Daniel, Jr.	No pneumoconiosis, suspicion of left upper lobe pulmonary nodule, mild pulmonary emphysema
6/24/98	DX 8	M.Patel	Simple pneumconiosis and carcinoma
6/24/98 (9/5/00)	DX 25	P. Wheeler/Board certified radiologist and B-reader	No evidence of silicosis or pneumoconiosis
6/24/98 (9/12/00)	DX 25	W. Scott/Board certified radiologist and B-reader	No evidence of silicosis or pneumoconiosis
6/24/98 (12/1/00)	DX 27	J.F. Wiot/Board certified radiologist and B-reader	No pneumoconiosis, COPD present
6/24/98 (12/22/00)	DX 28	H.B. Spitz/Board certified radiologist and B-reader	No pneumoconiosis, mass in left upper lobe, emphysema
6/24/98 (2/26/01)	DX 32	R.T. Shipley/ Board certified radiologist and B-reader	No pneumoconiosis, emphysema and chronic bronchitis due to cigarette smoking, evidence of primary lung cancer
6/24/98 (3/8/01)	DX 34	C.A. Meyers/Board certified radiologist and B-reader	No pneumoconiosis, emphysema, left lobe bronchogenic carcinoma
6/24/98 (4/1/01)	DX 36	S.V. Spagnolo	No pneumoconiosis
6/24/98 (10/4/01)	EX 3	J.R. Castle, B-reader	No pneumoconiosis, left upper lobe mass, emphysema
9/28/98	DX 8	M. Patel	Simple pneumconiosis and carcinoma
9/28/98 (9/5/00)	DX 25	P. Wheeler/Board certified radiologist and B-reader	No evidence of silicosis or pneumoconiosis
9/28/98 (9/12/00)	DX 25	W. Scott/Board certified radiologist and B-reader	No evidence of silicosis or pneumoconiosis
9/28/98 (12/1/00)	DX 27	J.F. Wiot/Board certified radiologist and B-reader	No pneumoconiosis, mass in left upper lobe
9/28/98 (12/22/00)	DX 28	H.B. Spitz/ Board certified radiologist and B-reader	No pneumoconiosis, mass in left upper lobe

9/28/98 (2/26/01)	DX 32	R.T. Shipley/ Board certified radiologist and B-reader	No pneumoconiosis, emphysema and chronic bronchitis due to cigarette smoking, evidence of primary lung cancer
9/28/98 (3/8/01)	DX 34	C.A. Meyers/Board certified radiologist and B-reader	No pneumoconiosis, emphysema, left lobe bronchogenic carcinoma - stable
9/28/98 (4/1/01)	DX 36	S.V. Spagnolo	No pneumoconiosis
1/11/99	DX 8	M. Patel	Simple pneumoconiosis and carcinoma
1/11/99 (9/5/00)	DX 25	P. Wheeler/ Board certified radiologist and B-reader	No evidence of silicosis or pneumoconiosis
1/11/99 (9/12/00)	DX 25	W. Scott/ Board certified radiologist and B-reader	No evidence of silicosis or pneumoconiosis
1/11/99 (12/1/00)	DX 27	J.F. Wiot/Board certified radiologist and B-reader	No pneumoconiosis, mass in left upper lobe
1/11/99 (12/22/00)	DX 28	H.B. Spitz/Board certified radiologist and B-reader	No pneumoconiosis, mass in left upper lobe
1/11/99 (2/26/01)	DX 32	R.T. Shipley/ Board certified radiologist and B-reader	No pneumoconiosis, emphysema and chronic bronchitis due to cigarette smoking, evidence of primary lung cancer
1/11/99 (3/8/01)	DX 34	C.A. Meyers/Board certified radiologist and B-reader	No pneumoconiosis, emphysema, left lobe bronchogenic carcinoma - progressive
1/11/99	DX 36	S.V. Spagnolo	No pneumoconiosis

C. Pulmonary Function Studies

DATE	EXHIBIT	HEIGHT	AGE	FVC	FEV_1	MVV	TRACINGS	EFFORT
11/20/85	DX 8	Not noted	Not noted	2.76 (Pre-bronchodilator results) 3.07 (Post-bronchodilator results)	1.59 1.7		Yes	Not noted
10/7/87	DX 8	71"	57	2.39 (Pre-bronchodilator results) 2.72 (Post-bronchodilator results)	1.39 1.54		Yes	Not noted

DATE	EXHIBIT	HEIGHT	AGE	FVC	FEV_1	MVV	TRACINGS	EFFORT
4/27/98	DX 8	71"	67	2.14 (Pre-bronchodilator results) 3.16 (Post-bronchodilator results)	.73 .78	28.7	Yes	Not noted

C. Arterial Blood Gas Studies

DATE	EXHIBIT	pCO_2 (mm.Hg.)	pO_2 (mm.Hg.)	RESTING/ AFTER EXERCISE
11/20/85	DX 8	40	65	Resting
3/11/86	DX 8	40	66	Resting
6/5/86	DX 8	42	63	Resting
10/7/87	DX 8	40.1	72	Resting
4/21/89	DX 8	37.7	64	Resting
4/27/98	DX 8	44.3	56	Resting
5/18/99	DX 8	45	67	Resting

D. West Virginia Pneumoconiosis Board Decision

The West Virginia Pneumoconiosis Board ("WV Board") issued a decision pertaining to the miner on September 1, 2000. (DX 26). The WV Board determined that coal workers' pneumoconiosis did not cause or contribute to the miner's death. The WV Board based this finding on the numerous medical records considered.

E. Medical Reports

Death Certificate

The miner's death certificate confirms that the miner passed away on August 14, 1999. (DX 7). The immediate cause of death is listed as pneumoconiosis and the certificate is signed by Dr. Maria Boustani.

Records of Southern West Virginia Clinic

The records of the Southern West Virginia Clinic are included in the record in this claim. (DX 8). These records are voluminous and included multiple office notes covering the time period of April 1969 through July 1999. As early as July 1972, the miner was noted to suffer from pneumoconiosis and mild to moderate emphysema. Chronic obstructive pulmonary disease was noted in subsequent office notes. It was also noted that the miner's condition deteriorated over time.

Dr. Maria Boustani

A report from Dr. Maria Boustani, dated September 3, 1999, is included in the record in this claim. (DX 9). The report states that in her first evaluation of the miner, Dr. Boustani noted that the miner exhibited shortness of breath with minimal exertion. Dr. Boustani also noted that this condition manifested as early as 1991. Dr. Boustani stated that the miner was diagnosed with silicosis as far back as 1977, and the miner's pulmonary function study showed severe obstruction with minimal improvement with the administration of bronchodilation.

After this initial visit, the miner continued to see Dr. Boustani for his care. The miner's condition was monitored through the use of chest x-rays and CT scans, which never permitted Dr. Boustani to make a "solid diagnosis of a malignancy." In a hospital stay just prior to the miner's death, it was noted that the miner was suffering from aspiration problems requiring the placement of a feeding tube.

Dr. Boustani explains that from April 1998 until the time of the miner's death, the miner suffered from "severe obstruction with severe hypoxemia that would get worse on minimal exertion and this, at no point improved throughout his treatment." Dr. Boustani stated that the miner was noted as having lung problems as early as 1973, while under the care of a different physician. Dr. Boustani also stated that the miner "got his disability and was diagnosed clearly to have pneumoconiosis, in 1988 according to clinic notes."

Dr. M.I. Ranavaya

On March 8, 2000, Dr. M.I. Ranavaya performed a medical consultant case review. (DX 10). Dr. Ranavaya is board certified in occupational medicine and is a B-reader. Dr. Ranavaya has served an Adjunct Associate Professor of Community and Occupational Medicine at the West Virgnia University School of Medicine and previously served as a clinical instructor. Dr. Ranavaya also serves as a governmental consultant and as a member of several advisory committees. Dr. Ranavaya found that the miner suffered from pneumoconiosis, but that the miner was not totally disabled due to pneumoconiosis prior to his death. Dr. Ranavaya found that the miner's death was not due to pneumoconiosis nor was pneumoconiosis a substantially contributing factor in the miners's death. The miner did not suffer from complicated pneumoconiosis and did not pass away due to complications from pneumoconiosis.

Dr. D.L. Rasmussen

Dr. D.L. Rasmussen authored a report pertaining to the miner on June 29, 2000. (DX 21). Dr. Rasmussen outlined numerous medical documents that he considered in rendering his opinion. Dr. Rasmussen noted 38 years of coal mine employment "much [of which was] prior to the institution of dust suppression in coal mines." The miner also had a significant cigarette smoking history.

Dr. Rasmussen opined that the miner suffered from a "very severe, totally disabling lung disease which ultimately lead to his death." Dr. Rasmussen went on to explain that both smoking and coal dust inhalation can cause chronic obstructive pulmonary disease. Based on the miner's occupational history and history of chest x-ray evidence of coal workers' pneumoconiosis, Dr. Rasmussen determined that the miner suffered from coal workers' pneumoconiosis. Dr. Rasmussen concluded that coal workers' pneumoconiosis "was a major contributing factor to his totally disabling and ultimately fatal chronic lung disease." Dr. Rasmussen opined that the miner's

coal workers' pneumoconiosis arose out of his coal mine employment and was a "major contributing factor" in the miner's death.

Dr. Rasmussen was also deposed in connection with this claim on November 27, 2001. (CX 1). Dr. Rasmussen reviewed his credentials which include being the Chief of Pulmonary Medicine at Appalachian Regional Hospital and the Director of the Appalachian Pulmonary Laboratory. (CX 1, p. 4). Dr. Rasmussen has been on the staff of the pulmonary division at the Southern West Virginia Clinic since 1986. (CX 1, p. 4). Dr. Rasmussen has specialized in the treatment of coal workers' pneumoconiosis since 1962 and has examined over 50,000 coal miners. (CX 1, p. 5). Dr. Rasmussen has testified before Congress regarding the black lung regulations. (CX 1, p. 5-6). Dr. Rasmussen is board certified in internal medicine and is a B-Reader. (CX 1, p. 6). Dr. Rasmussen successfully completed a pulmonary medicine fellowship. (CX 1, p. 6).

Dr. Rasmussen indicated that since the time of his June 2000 report, he had reviewed additional medical opinions from several physicians that did not change his opinion. (CX 1, p. 7). Dr. Rasmussen stated that he diagnosed coal workers' pneumoconiosis based on the miner's 35 years of coal mine employment and the chest x-ray readings of several B-readers. (CX 1, p. 7-8). Dr. Rasmussen explained that the miner suffered from a "very severe obstructive ventilatory impairment with a marked reduction in single breath carbon monoxide diffusion capacity." (CX 1, p. 8). Dr. Rasmussen also indicated that the miner suffered from significant hypoxemia with minimal exertion. (CX 1, p. 8).

Dr. Rasmussen noted a significant cigarette smoking history and explained that this history acted in concert with the miner's coal dust exposure to produce the miner's pulmonary condition. (CX 1, p. 8). Dr. Rasmussen opined that the miner's coal dust exposure was a "significant contributing factor to [the miner's] disability and ultimately fatal lung disease." (CX 1, p. 8). Dr. Rasmussen concluded that while he is unsure of the exact manner of the miner's death, he is sure that lung disease was the primary cause of the miner's death. (CX 1, p. 9). Dr. Rasmussen does not agree that the miner's death was due to lung cancer because there was "little or no evidence of wide-spread carcinoma." (CX 1, p. 9).

Dr. Rasmussen opined further that the miner's death was due to pulmonary failure and according to the death certificate, coal workers' pneumoconiosis. (CX 1, p. 9). Dr. Rasmussen stated that he believes that the miner was suffering from carcinoma, but considering the fact that a biopsy was not performed, he is unable to state definitively. (CX 1, p. 10). Dr. Rasmussen stated that both cigarette smoking and coal dust exposure can lead to the development of obstructive lung disease. (CX 1, p. 11). Dr. Rasmussen explained that the portion of the lung disease attributable to each cause cannot be determined. (CX 1, p. 11).

Dr. Rasmussen found that based on his experiences, coal dust exposure can lead to obstructive lung disease. (CX 1, p. 12). Dr. Rasmussen stated that it is common for there to be disparity among the readers of x-rays, but that when such disparity occurs, the use of chest x-rays to diagnose pneumoconiosis is unreliable. (CX 1, p. 13). Dr. Rasmussen explained that coal dust exposure can cause an impairment in lung function, sometimes significant, even without the presence of opacites in the lungs. (CX 1, p. 13). This is so because some individuals are more susceptible and more likely to experience a loss of capacity. (CX 1, p. 14).

Dr. Rasmussen concluded that the miner's death was hastened by and contributed to by the presence of pneumoconiosis. (CX 1, p. 14). Dr. Rasmussen indicated that while he is a

certified B-reader, he did not review the miner's chest x-rays or CT scans; however, Dr. Rasmussen stated that he took into consideration the reports of the miner's x-rays and CT scans. (CX 1, p. 15). Dr. Rasmussen acknowledged that the majority of the readings were negative for the existence of pneumoconiosis. (CX 1, p. 16).

Dr. Rasmussen explained that he assumes that the miner was suffering from lung cancer based on the miner's smoking history and chest x-rays and that the lung cancer would have eventually resulted in the miner's death. (CX 1, p. 17 & 21). Dr. Rasmussen further explained that the miner's smoking history was sufficient to cause a significant respiratory impairment and lung disease. (CX 1, p. 17). However, Dr. Rasmussen opines that the primary cause of the miner's death was lung disease because there is "no evidence to suggest that [the miner's] lung cancer increased his lung impairment, based on, at least x-rays several months before he died." (CX 1, p. 21).

Dr. Rasmussen explained that he reached his diagnosis of pneumoconiosis in part because a pulmonary impairment due to coal dust inhalation cannot be excluded and in part because he knows that coal dust can cause "this type of lung disease." (CX 1, p. 32). Dr. Rasmussen opined that the miner's problems could have been caused by coal dust exposure or cigarette smoking alone. (CX 1, p. 47). However, with significant coal dust exposure and a pulmonary impairment, Dr. Rasmussen would diagnose an occupationally induced disease even with negative x-rays readings. (CX 1, p. 48).

Samuel V. Spagnolo

Dr. Samuel V. Spagnolo issued a report pertaining to the miner on April 1, 2001. (DX 36). Dr. Spagnolo is a professor of medicine at George Washington University and an attending physician at George Washington Medical Center. (EX 1). Dr. Spagnolo is board certified in internal medicine and pulmonary disease. Dr. Spagnolo has held numerous public service positions, has appeared on radio and television programs and has testified before Congress and state legislators. Dr. Spagnolo reviewed numerous medical records and CT scans in rendering his opinion. Dr. Spagnolo also offered a detailed outline of the medical records in this claim.

Dr. Spagnolo noted that the miner was a chronic, heavy cigarette smoker. In early 1998, the miner exhibited lung cancer which Dr. Spagnolo explained leads to death within five years at the stage the miner exhibited. Dr. Spagnolo went on to explain that the miner then developed "progressive mediastinal involvement with resulting hemoptysis, chest pain, esophageal compression and pericardial effusion." The tumor then progressed and fluid developed around the miner's heart. A procedure was then performed to relieve the fluid around the miner's heart. Dr. Spagnolo opined that the miner suffered from primary lung cancer.

Dr. Spagnolo noted that the miner was told that his chest x-rays exhibited changes consistent with coal workers' pneumoconiosis. Dr. Spagnolo bases his finding that the chest x-rays do not exhibit changes consistent with pneumoconiosis on the readings of Drs. Wiot, Wheeler, Scott and Spitz. Dr. Spagnolo bases the weight accorded to these reports on the credentials and reports of these physicians. Dr. Spagnolo found no evidence of pneumoconiosis on the CT scans.

Dr. Spagnolo concluded that the miner did not suffer from any chronic restrictive or obstructive pulmonary disability arising out of coal mine employment. Dr. Spagnolo bases this conclusion on the Southern West Virginia Clinic records, the miner's spirometry, chest x-rays and

laboratory evidence. Dr. Spagnolo diagnosed the miner as suffering from obstructive lung disease brought on by cigarette smoking and exacerbated by sinusitis and coronary artery disease.

Dr. Spagnolo further concluded that even if the miner were found to suffer from pneumoconiosis, that the disease was too minimal to have contributed to the miner's death. Dr. Spagnolo opined that the miner passed away due to his progressive lung tumor and not due to any coal dust related condition. Dr. Spagnolo concluded that the miner's death was not related in any way to coal dust exposure and exposure to coal dust did not hasten or contribute to the miner's death.

Dr. Spagnolo issued a supplemental report dated January 5, 2001. (EX 7). The purpose of this report was to review the deposition testimony of Dr. Rasmussen. Dr. Spagnolo found that no restrictive or obstructive pulmonary disease was present that arose out of the miner's exposure to coal dust and that lung cancer was responsible for the miner's death. Dr. Spagnolo found no evidence presented by Dr. Rasmussen to change this conclusion.

Dr. John M. Daniel

Dr. John M. Daniel authored a report dated September 22, 2001 pertaining to the miner's condition. (EX 2). Dr. Daniel is on the active staff of one hospital and the courtesy staff at two hospitals. Dr. Daniel is board certified in family medicine and holds several administrative positions. Dr. Daniel reviewed the chest x-rays and CT scans of Miner over a 21 year period. Dr. Daniel noted that on March 26, 1980, the miner was diagnosed as suffering from pneumoconiosis by a local radiologist. Dr. Daniel also noted that the miner was examined by several physicians on numerous occasions where reference was made to chronic obstructive pulmonary disease secondary to cigarette smoking.

Dr. Daniel made reference to the chest x-rays and CT scans that were reviewed by "expert radiologists of a university status" where no pneumoconiosis was found. Dr. Daniels stated that based on these readings, he felt "that there is not significant or objective evidence to substantiate a diagnosis of coal workers' pneumoconiosis in" the miner. Dr. Daniel bolsters his opinion by pointing out that the miner showed evidence of a mild respiratory impairment in 1980, but that the problem was not present in 1985 indicating a reversible aspect to the impairment.

Dr. Daniel stated that the miner's pulmonary function studies showed a severe obstructive lung disease that was secondary to cigarette smoking and resulted in chronic obstructive pulmonary disease. Dr. Daniel opined that an asthmatic component was present because the miner's condition showed improvement with the administration of bronchodilation. Dr. Daniel determined that none of the miner's pulmonary impairment was due to pneumoconiosis.

Dr. Daniel found no evidence of disability secondary to pneumoconiosis but did find a severe obstructive lung disease that resulted from a 30 year cigarette smoking history. Dr. Daniel believes that this smoking history was the primary cause of the miner's pulmonary problems. Dr. Daniel concluded that pneumoconiosis did not contribute to nor hasten the miner's death due to lung cancer. Dr. Daniel stated that the miner's death was due to chronic obstructive pulmonary disease and lung cancer, neither of which are attributable to coal dust exposure. Dr. Daniel concluded that even if the miner were found to have suffered from pneumoconiosis, it would have been simple pneumoconiosis and therefore, not have played any role in the miner's death.

Dr. James R. Castle

Dr. James R. Castle authored a report dated October 4, 2001 pertaining to the miner. (EX 3). Dr. Castle is board certified in internal medicine and pulmonary disease and is a B-reader. Dr. Castle holds and has held several academic appointments. Dr. Castle is on the staff of three hospitals and is a clinical professor in family medicine and internal medicine at the University of Virginia School of Medicine. (EX 5, p. 6-8). Dr. Castle is involved in research for new pulmonary disease treatment drugs. (EX 5, p. 8).

Dr. Castle found no evidence of the existence of pneumoconiosis based on the miner's medical history, physical examinations, chest x-rays, objective testing, arterial blood gas studies, outpatient records and all other available data. Dr. Castle noted 36 years of coal mine employment and a 2 pack per day smoking habit for 40 years. Dr. Castle found no evidence of a chronic interstitial pulmonary process; and Dr. Castle is of the opinion that there is no radiographic evidence of coal workers' pneumoconiosis.

Dr. Castle opined that the miner's chest x-rays showed pulmonary emphysema and the CT scans reveal a left upper lobe mass with no evidence of coal workers' pneumoconiosis. Dr. Castle opined that the miner's physiologic studies showed a progressive severe obstructive airway disease. Dr. Castle found this obstructive airway disease to be associated with the miner's reduction in diffusing capacity which indicates a cigarette smoking induced pulmonary emphysema. Dr. Castle explained that a reduction in diffusing capacity does not usually occur with coal workers' pneumoconiosis, and when it does, it is associated with a high degree of abnormality. Dr. Castle concluded that the miner's severe obstructive disease with severe diffusion capacity impairment indicates cigarette smoking induced pulmonary emphysema.

Dr. Castle went on to explain that the miner developed evidence of bronchogenic carcinoma. Dr. Castle attributes the miner's significant exercise induced hypoxemia and blood gas abnormalities to this condition. Dr. Castle did not find the presence of pneumoconiosis based on his physical, radiographic, or physiologic findings. Dr. Castle found the miner's pulmonary emphysema to be disabling, but none of the disability to be attributable to coal dust exposure.

Based on the miner's clinical course and radiographic evidence, Dr. Castle found that the miner had developed primary bronchogenic carcinoma in the left upper lobe of the lung. Dr. Castle explained that this condition progressed "fairly rapidly" and led to the miner's death in August 1999. Dr. Castle opined that the miner died as a complication of the bronchogenic carcinoma caused by the miner's smoking history and that there was no evidence that "coal workers' pneumoconiosis caused, contributed to, or hastened [the miner's] death in any way." Dr. Castle indicated that even if pneumoconiosis were found, his opinion as to the cause of the miner's pulmonary impairment and death would remain unchanged.

Dr. Castle was also deposed in connection with this claim on November 6, 2001. (EX 5). Since the time of his initial report, Dr. Castle had reviewed the reports of Drs. Daniel, Fino and Rosenberg. (EX 5, p. 11). Dr. Castle explained that he observed interstitial infiltrates in the miner's lungs, but that those infiltrates were related to the miner's lung cancer and not pneumoconiosis. (CX 5, p. 13). Dr. Castle opined that the miner's chest x-rays and June 24, 1998 CT scan showed no evidence of pneumoconiosis. (CX 5, p. 12-13 & 14-16).

Dr. Castle also discussed the miner's significant smoking history. (EX 5, p.18). Dr. Castle indicated that the miner smoked at least two packs per day for 40 years, which is sufficient to develop chronic obstructive pulmonary disease, chronic bronchitis, emphysema or lung cancer.

(EX 5, p. 18). Dr. Castle went on to state that the miner suffered from a severe respiratory disability due to the miner's smoking history. (EX 5, p. 20). Dr. Castle found no credible evidence that the miner's disability was related to coal dust exposure. (EX 5, p. 20). Dr. Castle disagrees with the assertion on the miner's death certificate that the miner died from pneumoconiosis because it is "absolutely clear" that the miner died from lung cancer. (EX 5, p. 23).

Dr. Castle also took issue with Dr. Rasmussen's conclusion that the miner's death was caused in substantial part by pneumoconiosis because Dr. Castle does not believe that the miner suffered from pneumoconiosis. Dr. Castle also does not believe that any evidence exists to establish that pneumoconiosis played any role in the miner's death. (EX 5, p. 24).

Dr. Castle also authored a supplemental report dated January 4, 2002. (EX 6). In this report, Dr. Castle takes issue with Dr. Rasmussen's deposition testimony. Dr. Castle does not believe that Dr. Rasmussen utilized all of the objective data available. Dr. Castle also takes issue with Dr. Rasmussen's finding that the miner's lung cancer was not related to his death because there is no evidence that the cancer had progressed. Dr. Castle points out that Dr. Rasmussen must have been unaware of the mediastinal involvement of the miner's cancer. Dr. Castle believes that Dr. Rasmussen ignored the fact that the miner's clinical records indicate evidence of tobacco smoke induced bronchogenic carcinoma.

Dr. Gregory Fino

Dr. Gregory Fino authored a report pertaining to the miner's death dated October 4, 2001. (EX 4). Dr. Fino is board certified in internal medicine and is a B-reader. Dr. Fino has six hospital appointments and is an associate professor of medicine in the pulmonary division at the University of Pittsburgh Medical School. Dr. Fino noted 37 years of coal mine employment with the miner's last coal mining job was as a surface utility person in 1985.

Dr. Fino reviewed and summarized the medical evidence available at the time of his report. The first issue dealt with by Dr. Fino is the death certificate that lists the cause of death as pneumoconiosis. Dr. Fino believes that there is no objective evidence to support this as the cause of death. Dr. Fino opines that pneumoconiosis did not cause, contribute, or hasten the miner's death. Dr. Fino opines further that there is no medical record evidence that supports the finding of pneumoconiosis as the cause of death and to make such a designation is speculative.

Next, Dr. Fino opines that the chest x-ray and CT scan evidence establishes that the miner was suffering from lung cancer. Dr. Fino notes that the miner was a heavy cigarette smoker. Dr. Fino also noted that the miner suffered from a pericardial effusion which is frequently associated with lung cancer. Dr. Fino found that the miner suffered from severe chronic obstructive pulmonary disease with reversibility after bronchodilation. Dr. Fino pointed out that the miner's resting blood oxygen levels varied. These factors indicate to Dr. Fino that the miner was suffering from a cigarette smoking induced lung disease which was not caused by coal dust exposure.

Dr. Fino concluded that the miner was disabled from a pulmonary standpoint, but that disability was not caused, contributed to, nor aggravated by exposure to coal dust. Dr. Fino also concluded that the evidence did not justify a diagnosis of pneumoconiosis or any occupationally acquired pulmonary condition. Dr. Fino opined that the miner's death was most likely due to lung cancer from cigarette smoking. Dr. Fino found "no evidence to show that [the miner's] death was caused, contributed to or hastened by coal dust inhalation." Dr. Fino concluded that even if the miner were found to suffer from pneumoconiosis, his opinion as to the miner's death would remain unchanged.

Dr. Fino was also deposed in connection with this claim on January 10, 2002. (EX 9). Dr. Fino reiterated the findings of his report and reviewed his credentials. (EX 9, p. 3-5). Dr. Fino explained that he treats patients with coal workers' pneumoconiosis as well as patients with smoking related illnesses. (EX 9, p. 4). Dr. Fino explained further that the typical diseases associated with cigarette smoking are chronic bronchitis or emphysema and on some occasions, lung cancer. (EX 9, p. 4-5).

Dr. Fino stated that the miner was exposed to significant amounts of coal dust, but that no coal workers' pneumoconiosis was present. (EX 9, p. 5). Dr. Fino opined that all of the miner's lung abnormalities were related to cigarette smoking and none were related to coal dust exposure. (EX 9, p. 5). Dr. Fino bases this finding on the fact that the chest x-rays and CT scans rule out the existence of pneumoconiosis. (EX 9, p. 6).

Dr. Fino explained further that when an autopsy is not performed, all opinions as to the cause of death are speculative in nature. (EX 9, p. 9). Dr. Fino opined that the most recent medical evidence pertaining to the miner "strongly suggested that [the miner] had a very, very serious problem developing, which is fluid around the heart, which can compress the heart, prevent it from adequately pumping and can cause instantaneous death." (EX 9, p. 10). Dr. Fino concluded by taking issue with Dr. Rasmussen's finding that the miner died as a result of severe lung disease. (EX 9, p. 11). Dr. Fino believes that the miner did not die as a result of any lung disease related to coal dust exposure. (EX 9, p. 11).

Dr. David M. Rosenberg

Dr. David M. Rosenberg issued a report pertaining to the miner's death on October 8, 2001. (EX 4). Dr. Rosenberg is the Medical Director of University Occupational Health Services at Chagrin Highlands University Hospitals in Cleveland, Ohio, and is an Associate Clinical Professor at the Case Western Reserve University School of Medicine. Dr. Rosenberg's private practice consists of pulmonary disease and internal medicine, and is board certified in internal medicine, pulmonary disease and occupational medicine. Dr. Rosenberg is a certified B-reader. Dr. Rosenberg reviewed numerous medical documents pertaining to the miner's care and treatment in rendering his opinion.

Dr. Rosenberg noted 34 years of coal mine employment with most of those years conducting work underground. As of the date of the miner's death, Dr. Rosenberg noted that the miner was 69 years old and had a long and significant smoking history. Dr. Rosenberg also notes that the miner was suffering from severe chronic obstructive pulmonary disease based on the pulmonary function studies. Dr. Rosenberg also notes that the miner's chest x-rays and CT scans were read as being negative for the existence of pneumoconiosis. A left upper lobe lung mass is also noted in the miner's history.

Dr. Rosenberg found that the majority of the miner's chest x-rays and CT scans did not indicate the presence of any "interstitial component of coal workers' pneumoconiosis." The pulmonary function studies showed a severe obstructive component to the miner's lung disease. Dr. Rosenberg went on to explain that "[w]hile coal dust exposure and CWP have been associated with the development of airflow obstruction, the extent and manifestations of [the miner's] chronic obstructive pulmonary disease were related to his long and continued cigarette smoking and not coal dust exposure." Dr. Rosenberg opined that this severity of airflow obstruction does not occur with coal workers' pneumoconiosis or coal dust exposure unless complicated pneumoconiosis is found.

Dr. Rosenberg concluded that the miner would have been unable to engage in his last coal mine employment or any comparable employment. However, Dr. Rosenberg found that the miner's condition was not related to the inhalation of coal dust or coal workers' pneumoconiosis. Dr. Rosenberg found no condition to be present that contributed to the miner's death that was caused by coal dust exposure. Dr. Rosenberg concluded that the miner's death was caused by lung cancer which was caused by the miner's smoking history.

Dr. Rosenberg diagnosed the miner as suffering from chronic obstructive pulmonary disease due to the miner's extensive cigarette smoking history. Dr. Rosenberg found that "[c]oal dust exposure did not contribute in any clinically significant manner to his obstructive dysfunction." The miner's lung cancer was brought about from the miner's cigarette smoking history and that lung cancer caused the miner's death. Dr. Rosenberg believes that coal dust exposure "did not cause or contribute in any clinically significant fashion to his disability or death." Dr. Rosenberg's opinion as to the miner's death would not change if pneumoconiosis were found to be present.

Dr. Rosenberg issued a supplemental report on January 4, 2002. (EX 8). At that time, Dr. Rosenberg reviewed the deposition testimony and articles submitted by Dr. Rasmussen. Dr. Rosenberg outlined the findings of the articles and took issue with Dr. Rasmussen's conclusions. Dr. Rosenberg disagrees with Dr. Rasmussen that an inflammatory process is most likely responsible for the development of pulmonary disorders associated with coal dust exposure. Dr. Rosenberg states that whether clinically severe chronic obstructive pulmonary disease develops with exposure to coal dust must be based on the physiological studies performed. Dr. Rosenberg's opinion of October 2001 remains unchanged as he believes that the miner's chronic obstructive pulmonary disease was caused by the miner's cigarette smoking and not coal dust exposure.

CONCLUSIONS OF LAW

Length of Coal Mine Employment

Employer has agreed that the miner was a miner within the meaning of the Act for 30 years. (TR 8). I find that this is supported by the evidence of record. Therefore, I find that Raymon Herron was a coal miner within the meaning of the Act for 30 years.

Dependents

Employer has agreed that the miner has one dependent for the purposes of augmentation. (TR 8). Accordingly, I find that the miner's spouse, Johnnie Ruth qualifies as a dependent for the purposes of augmentation under the Act.

Responsible Operator

Employer has offered no evidence to dispute the fact that it is the properly designated responsible operator in this claim. Therefore, I find that Westmoreland Coal Company is the properly designated responsible operator and will provide for the payment of any benefits awarded to Claimant.

Existence of Pneumoconiosis

The regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§718.304, 718.305 and 728.306, and medical opinions. §718.202(a)(1)-(4). The first method provided for in the regulations to establish the existence of pneumoconiosis is by chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). There are fifty-four interpretations of nineteen different x-ray films contained in the record as part of Claimant's claim for benefits.

Fifteen of the readings are positive for the existence of pneumoconiosis. The credentials of the readers finding the existence of pneumoconiosis are not included in the record in this claim. The remaining thirty-six interpretations are negative for the existence of pneumoconiosis. Thirty-five of the negative readings were rendered by dually qualified physicians and one was rendered by a physician whose credentials are not included in the record.

A judge is not required to defer to the numerical superiority of x-ray evidence. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990). Where two or more x-ray reports are in conflict, the radiological qualifications of the physicians interpreting the x-rays must be considered. (*See* 20 C.F.R. § 718.202 (a)(1)). Great weight may be given to B-readers due to their expertise. *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-689 (1985). The interpretations of dually qualified physicians are entitle to more weight than the interpretations of B-readers. *Herald v. Director, OWCP*, B.R.B. No. 94-2354 BLA (Mar. 23, 1995) (unpublished). Moreover, it is improper to accord greater weight to the interpretations of a physician whose qualifications are unknown. *Stanley v. Director, OWCP*, 7 B.L.R. 1-386 (1984). If the film quality is "poor" or "unreadable," then the study may be given little weight. *Gober v. Reading Anthracite Co.*, 12 B.L.R. 1-67 (1988).

I accord the most weight to the interpretations of dually qualified physicians. I also accord great weight to the interpretations of the B-readers. I accord less weight to the readings of physicians whose credentials are not included in the record in this claim. I also accord less weight to the readings that were rendered many years before the miner's death. I find that the overwhelming weight of the chest x-ray evidence does not support a finding of the existence of pneumoconiosis. Accordingly, I find that Claimant has failed to establish the existence of pneumoconiosis by a preponderance of the chest x-ray evidence.

Also included in the record in this claim are twenty-five readings of four CT scans. All but three of these readings are negative for the existence of pneumoconiosis. The credentials of the physician rendering the three positive readings are not included in the record. Twenty of the negative CT scan readings were rendered by dually qualified physicians, three were rendered by a board certified internist with a pulmonary disease specialty and one was offered by a certified B-reader. While the regulations do not specifically address CT scans, I have considered them in conjunction with the chest x-ray readings, and I find that Claimant has failed to establish the existence of pneumoconiosis.

Claimant has failed to establish the existence of pneumoconiosis by the second and third methods because there is no biopsy evidence and the miner passed away after March 1, 1978 without evidence of complicated pneumoconiosis with the claim being filed after January 1, 1982. 20 C.F.R. §§ 718.202(a)(2) and (a)(3).

The fourth method available to claimant to establish the existence of pneumoconiosis is by a reasoned medical opinion from a physician establishing that claimant suffers from a respiratory

or pulmonary impairment arising out of coal mine employment or by meeting the definition of pneumoconiosis provided at 20 C.F.R. § 718.201. 20 C.F.R. § 718.202(a)(4). Section 718.201 defines pneumoconiosis as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment...[a] disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." Legal pneumoconiosis is defined by § 718.201(a)(2) as including "but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment."

Opinions from eight physicians appear as part of the record in the miner's current claim for benefits under the Act. Dr. Maria Boustani found that the miner's cause of death was pneumoconiosis and that the miner had suffered from this condition since the mid-1980s "according to the clinic notes." (DX 9). Dr. Boustani offers no explanation for this conclusion. This Court is aware that Dr. Boustani served as the miner's treating physician; however, the lack of rationale for Dr. Boustani's opinion entitles the opinion to less weight. The records of the Southern West Virginia Clinic indicate that the miner was diagnosed with pneumoconiosis as early as July 1972. (DX 8). However, these records are of little value as there is no indication of how this diagnosis was reached. Dr. Ranavaya offered a cursory opinion of the miner's condition. (DX 10). Dr. Ranavaya possesses impressive credentials, but no rationale is given for his opinion. Therefore, it is entitled to less weight.

Dr. Rasmussen found that the miner suffered from coal workers' pneumoconiosis based on the miner's years of exposure to coal dust as well as the chest x-ray readings of several certified B-readers. (DX 21, CX 1). Dr. Rasmussen also noted that the miner had a significant cigarette smoking history. Dr. Rasmussen opines that the smoking history and the history of coal dust exposure worked together to cause an obstructive lung disease in the miner. Dr. Rasmussen did not review the miner's chest x-rays or CT scans; however, Dr. Rasmussen believes that when disparity exists, the use of x-ray readings to rule out a diagnosis is unreliable. Dr. Rasmussen's diagnosis of coal workers' pneumoconiosis in the miner was based on the fact that a pulmonary impairment due to coal dust inhalation cannot be ruled out, as well as the fact that Dr. Rasmussen is confident that coal dust exposure can cause an obstructive lung impairment. Dr. Rasmussen concluded that even in the face of negative x-ray readings, he would diagnose an occupationally acquired lung disease if the person had significant coal dust exposure and suffered from a pulmonary impairment.

Dr. Spagnolo opined that the miner did not suffer from coal workers' pneumoconiosis based on the negative chest x-ray readings of Drs. Wiot, Wheeler, Scott and Spitz and his own readings of the CT scans. (DX 36, EX 7). Dr. Spagnolo also possesses impressive credentials. Dr. Spagnolo found that the miner suffered from chronic obstructive pulmonary disease due to the miner's cigarette smoking history. Dr. Spagnolo found no obstructive or restrictive lung disease due to the inhalation of coal dust. Dr. Spagnolo found the existence of lung cancer. Dr. Daniel also found the existence of lung cancer, but found no evidence to substantiate a finding of coal workers' pneumoconiosis. (EX 2). Dr. Daniel reviewed the miner's chest x-rays and CT scans taken over twenty-one year period and found that the miner suffered from chronic obstructive pulmonary disease due to a 30 year cigarette smoking history. Dr. Daniel also found that the miner's pulmonary condition showed reversibility, which is not usually seen with coal workers' pneumoconiosis. Based on the chest x-ray readings of physicians of a "university status" as well as the aforementioned information, Dr. Daniel determined that the miner did not suffer from coal workers' pneumoconiosis.

Dr. Castle found that the miner did not suffer from coal workers' pneumoconiosis based on the miner's medical history, physical examinations, chest x-rays, objective testing, arterial blood gas tests, outpatient records and all other available data. (EX 3 & 5). Dr. Castle, who possesses impressive credentials, noted that the miner had 36 years of coal mine dust exposure and smoked two packs of cigarettes per day for 40 years. Dr. Castle found no radiographic evidence of pneumoconiosis, but did find that the chest x-rays and CT scans showed pulmonary emphysema and a lung mass. Dr. Castle found the existence of lung cancer, but no coal workers' pneumoconiosis.

Dr. Gregory Fino noted that the miner was exposed to coal dust for 37 years. (EX 4 & 9). Dr. Fino found that pneumoconiosis was not the cause of the miner's death, and that there was no medical evidence to support a finding of pneumoconiosis. Dr. Fino opined that the chest x-rays and CT scans showed lung cancer and chronic obstructive pulmonary disease caused by a significant cigarette smoking history. Dr. David Rosenberg noted significant coal dust exposure as well as a significant cigarette smoking history. (EX 4 & 8). Dr. Rosenberg opined that the miner suffered from chronic obstructive pulmonary disease due to his cigarette smoking history. Dr. Rosenberg found no radiographic or CT scan evidence of the existence of pneumoconiosis. Dr. Rosenberg opined that the miner did not suffer from a coal dust related pulmonary condition.

I find that the miner did not suffer from pneumoconiosis arising out of his coal mine employment at the time of his death. Legal pneumoconiosis is defined by § 718.201(a)(2) as including "but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." This statement makes clear that the pulmonary disease must arise out of coal mine employment. It is clear from the evidence that the miner was suffering from an obstructive lung disease at the time of his death. There is no evidence to contradict this finding. However, there is a disagreement among the physicians concerning the cause of the miner's condition. Dr. Rasmussen found that the miner's obstructive lung condition was caused by a combination of coal dust exposure and cigarette smoking. Drs. Spagnolo, Daniel, Castle, Fino and Rosenberg all found that the miner's condition arose from his cigarette smoking history, as they all did not find the existence of pneumoconiosis.

I find Dr. Rasmussen has impressive credentials and that he offered a well-supported opinion in support of Claimant's assertion that the miner suffered from coal workers' pneumoconiosis. However, in the face of the well-documented and well-reasoned opinions of the other physicians of record, Dr. Rasmussen's opinion is entitled to less weight. Drs. Spagnolo, Daniel, Castle, Fino and Rosenberg all possess impressive credentials and authored well-reasoned and well-documented reports. As such, I find that Claimant failed to establish the existence of pneumoconiosis arising out of coal mine employment by the fourth method available under the regulations.

Weighing all of the evidence together, I find that Claimant has failed to establish the existence of pneumoconiosis arising out of coal mine employment in accordance with the applicable regulations. An administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffers from pneumoconiosis. *Island Creek Coal Co. v. Compton,* 211 F.3d 203 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams,* 114 F.3d 22 (3rd Cir. 1997). The x-ray evidence in this claim does not establish the existence of pneumoconiosis by a preponderance of the evidence. There is no biopsy or autopsy evidence, and the presumptions of §§ 718.304, 718.305, and 718.306 are inapplicable. Claimant has not established pneumoconiosis by a preponderance of the physician opinion evidence. Therefore, I find that claimant has failed to establish the existence of pneumoconiosis arising out of coal mine employment.

Considering that the miner has not been found to suffer from pneumoconiosis arising out of coal mine employment, it is not necessary to address the remaining issues.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to claimant for services rendered to him in pursuit of this claim.

ORDER

It is hereby ordered that the claim of Johnnie Ruth Herron, survivor of Raymon Herron, for benefits under the Black Lung Benefits Act is hereby DENIED.

A
ROBERT J. LESNICK
Administrative Law Judge

NOTICE OF APPEAL RIGHT: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order by filing notice of appeal with the ***Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of notice of appeal must also be served on *Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.*